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ABSTRACT

The paper raises concerns about current intervention practices used with children who, while not handicapped, have academic and/or behavioral problems and who may be labeled handicapped. A lack of options for these high risk students is noted in regular programs, and the impact on the student and the system of the referral-to-testing-to-labeling process is explored. The paper suggests the need to examine notions about interventions and to see prereferral interventions as a series of preventive interventions. It is suggested that interventions may be viewed as strategic or nonstrategic actions, and may be classified as proactive (strategic modification at the classroom level), reactive (nonstrategic actions lacking a goal-directed, integrated, planned effect), or protensive (strategic and precautionary actions having continuance in time). The paper concludes by calling on practitioners to implement and evaluate preventive interventions before students are referred. References are appended. (CL)

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WHEN IS INTERVENTION AN OUNCE OF PREVENTION?

RECONCEPTIONALIZING THE PREREFERRAL INTERVENTION PROCESS

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When is Intervention an Ounce of Prevention?

Reconceptualizing The Prereferral Intervention Process

Abstract

The purpose of this paper is to raise some questions about current intervention practices used by real school people in regular school programs as they deal with children who experience academic and/or behavioral problems. The paper focuses upon prereferral interventions used as preventative interventions for children who are not handicapped, but who are low achievers, and who may be labeled as handicapped, if school resources are not appropriately used. Methodological issues embedded in conceptualizing effective prereferral interventions as preventative actions are discussed. Currently, prereferral interventions are viewed as all inclusive actions. However, the author invites researchers and practitioners to examine the qualitative aspects of interventions. This paper suggests that interventions may be strategic or non-strategic actions and the author suggests there are at least three possible ways of looking at interventions, as proactive, reactive, and protensive intervention actions.

WHEN IS INTERVENTION AN OUNCE OF PREVENTION?

RECONCEPTUALIZING THE PREREFERRAL INTERVENTION PROCESS

What happens when a child in a regular education program begins to have problems in school? What interventions are most effective and serve as preventative measures to forestall disaster? The purpose of this paper is to raise some questions about the methodological issues embedded in these two questions, and to foster discussion about interventions used by real school people in regular school programs, as they deal with children who experience academic and/or behavioral problems. Currently, prereferral interventions are viewed as all inclusive actions and we assume (perhaps incorrectly) that they are preventative. However, I would like to invite researchers and practitioners to examine the qualitative aspects of interventions. As such, I suggest three possible ways of looking at prereferral interventions, as PROACTIVE, REACTIVE, AND PROTENSIVE intervention actions, of which "reactive" may not involve preventative prereferral actions.

To begin, let's look at how we conceptualize the term, "intervention". Specifically, let's examine prereferral interventions used as preventative interventions for "at risk" children who are not handicapped, but who are low achievers, and who may be labeled as handicapped, if school resources are not used appropriately. Let's examine the possibility that we need to extend efforts to interpose systematic interventions prior to, or instead of referring children to special education programs.

Why are these questions of interest? A recent report from the Council of Great City Schools (1986) describes an alarming situation. Special education directors see increasing numbers of "at-risk" students referred to special education due to a lack of options in regular programs. The largest number of students identified as handicapped are in the specific learning disabled category and the disproportionate numbers suggest that some of these students are misidentified as handicapped. It seems likely that this category is sometimes misused for placement of average ability students exhibiting poor performance or motivation problems. Studies describing overuse of the specific learning disability category, combined with increasing numbers of referrals to mildly handicapped placements, support this view. Options other than special education placement are needed for students who are not, in fact handicapped, but who may be labeled as such if they get swept away in the special education river. "At risk" are the low achieving students whose academic and/or behavioral problems create sufficient staff concerns to result in a referral into the muddy waters of special education screening, diagnosis, and placement. Once these students arouse staff concerns and they are referred, the likelihood that they will be labeled is especially great. The probability that "at risk" students will be labeled may be even more likely in school systems where regular education teachers and staff, believe that special education controls access to resources.

Who are the students in need of preventative interventions? "At risk" students are those who are not handicapped but who need effective alternative interventions to succeed in a regular school program. Some "at risk" indicators for students are:

- academic problems, such as basic skill deficiencies in reading and math
- low achievement and/or motivation
- poor self-concept
- slow rate of learning when compared to peers
- inattention during classroom activities
- acting out or attention-getting behaviors
- poor attendance patterns
- poor work habits and/or organizational skills
- social or cultural experiences which differ from community norms

Many "at risk" students receive handicapping labels on the basis of these indicators and are most often described as learning disabled (Shepard, Smith, & Vojir, 1983; Ysseldyke & al., 1982a; 1982b). Although nearly two million students were identified as learning disabled as of 1985, studies suggest that many of these so-called handicapped students are inappropriately labeled (Algozzine & Ysseldyke, 1983; Argulewicz, 1983; Forness & al., 1983; Mehan & al., 1986; Tucker, 1980).

A tremendous body of research during the past 5 years documents the difficulty in distinguishing accurately between learning disabled and low-achieving students and describes the ease with which "at risk" students are identified as learning disabled and receive services from special education (Shepard and Smith, 1983; Ysseldyke, Algozzine, & Epps, 1983; Shinn, Tindal, Spira, & Marston, 1987). The reality, as Shepard (1987) describes it, is that about 10% of the identified handicapped have severe and absolute handicapping conditions. Approximately 90% of all identified handicapped students are very mildly handicapped. Although the majority of the mildly handicapped are labeled as learning disabled, some observers believe that as many as half of these students should not have handicapping labels. At least half of the learning disabled population look very much like low achievers (Shepard, 1987; Ysseldyke, Algozzine, Shinn, & McGue, 1982).

This is the setting that led Sleeter (1986) to develop a tongue-in-cheek axiom that loosely translates into "any low achiever who does not fit an existing explanation for low achievement is learning disabled; since a discrepancy between normal and potential achievement not explained by obvious physical, neurological, sensory, emotional, or experiential deficits' describes most students."

Despite attempts to clarify the legal or scientific definitions used to justify mildly handicapping labels, some observers describe a common phenomenon in which schools widely employ a social-policy definition of learning disabilities designed to serve students most deficient in achievement (Shinn, Tindal, Spira, & Marston, 1987). Pugach (1987) suggests that special education classes have become the placement of choice for students who are not achieving in regular classrooms. These are the students labeled as learning disabled (perhaps inappropriately) so that they can get the help they need. Even interviews of clinicians suggest that they sometimes purposely (intentionally) misidentify children to obtain services (Shepard, 1983).

What are the reasons for referrals? Pugach (1987) suggests that some students who are referred and labeled (inappropriately) are those whose problems in school are attributable to less than optimal teacher/classroom conditions. Teachers typically refer students who demonstrate bothersome

behaviors in the classroom (e.g., difficulty with on-task behaviors, lack of attention, hyperactivity, difficulty in understanding, slowness in completing work) and the reason for referral (e.g., academic or behavior problems) is a good predictor of subsequent special class placement (e.g., LD or ED) for many students (Algozzine & Ysseldyke, 1986). We suspect that referred students are functioning successfully outside the class norm (whatever that is).

The literature is ripe with speculations of why teachers readily refer difficult students to special education. Shepard (1987) suggests that teachers in training are taught a referral model (i.e., to solve a problem by finding the appropriate external resources). Gerber and Semmel (1984) suspect that teachers refer the lowest performing students in an apparent effort to reduce classroom variance in instructional grouping and to allocate limited teaching resources more efficiently. Still another view is that educational practices enacted as a routine part of organizational life are responsible for referrals and mild disability labels (Mehan, Hertweck and Meihls, 1986).

Regardless of the reason for referral, the construction of an educationally handicapped student's career starts when the teacher makes that initial referral. Often, the teacher has only a general notion that a student is in trouble, or needs help. This initial, rather general attribute which establishes the presumption of a handicap, becomes refined as more and more institutional machinery (e.g., tests, committee meetings, observations, home visits) is applied to the case until, finally by the time of the placement meeting, only a parent's refusal to sign the pertinent documents changes the assumed placement (Mehan, Hertweck, & Meihls, 1986). However, as Pugach, (1985) notes, the individual teacher's decision to refer a student continues to be a pivotal point in the identification process. In fact, we can safely say that students who are never referred for evaluations probably will never be labeled as handicapped. Once extensive evaluations are conducted, a majority of referred students are declared eligible to receive special education services, typically in resource rooms for the mildly handicapped.

What is the impact of the referral-to-testing-to-labeling process? The referral, evaluation, and placement of students in special education places excessive demands on special education resources. Once the referral process begins, the probability that a student will receive special services is quite high. As early as 1978, New York City schools found 45% of all students tested for special education were labeled (Algozzine & Ysseldyke, 1981). Presently, estimates run as high as 75-90% (Algozzine, Christenson, & Ysseldyke, 1982) for students deemed eligible and classified (i.e., labeled) as learning disabled. Teachers continue to refer students they suspect to be learning disabled, often without trying adequate prereferral interventions prior to referral (Smith, 1986). School districts are faced with expensive identification and assessment practices (Mirkin, 1980; Ysseldyke, Thurlow, Graden, Wesson, Algozzine, & Deno, 1983). The growing numbers of inappropriately labeled learning disabled students reduces the resources for helping the most severe cases, for whom the label was intended (Poplin, 1981).

Costs of providing remedial help through special education are huge and may cause the eventual collapse of the whole system. It costs about \$5 to place a child in Chapter I programs but estimates of the initial costs for

learning disability labels range from \$600-\$1000 per child. Most of the costs go for staff time spent on testing and paperwork, leaving a smaller portion of special education resources for actual instructional programs (Shepard, 1983; 1987); thus leading many school systems to initiate prereferral activities designed to lower the number of inappropriate referrals. The Great Cities Report (1986) notes that districts reporting high placement rates uniformly require prereferral activities to lower the number of inappropriate referrals, but questions arise as to the way preventative interventions are conceptualized and carried out by participating schools.

What do we mean by preventative interventions? The term intervention has particular meaning to those of us in the field of special education. The term occurs most often in discussions about how to provide the most efficacious services to children who have been identified as handicapped. In the field of learning disabilities, the term is used again and again to categorize the various methodologies to remediate or obliterate specific deficits, which are believed (by some) to be inherent in learning disabled students. In the world of special educators, interventions usually occur after-the-fact of a handicapping label.

Preventative interventions, on the other hand, are precautionary efforts, interposed as an obstacle to forestall events. As special educators, it is easy to believe that we can not "prevent" a handicapping condition, and in the case of severe and absolute handicapping conditions, including actual learning disabilities, perhaps this is so. However, note that when we talk about prevention as a way of forestalling "events" (i.e., referring a child for evaluation) or altering educational practices (i.e., setting up systematic classroom interventions), we bring a different view to the concept of intervention as a preventative mechanism.

Perhaps, it is time to examine our notions about interventions and recognize that what we actually mean when we describe "prereferral" interventions is a series of preventative interventions. Before beginning to evaluate the supposed effectiveness of prereferral interventions, it is essential to consider the relationship between an intervention, as an action and the purpose, whether tacit or explicit, for that action. If the purpose of an intervention is to compel an effect (i.e., student success) or prevent an event (i.e. inappropriate student referral to special education), we must ask ourselves, what we intend to maintain, change, and prevent when we intervene to help "at risk" students. Should we expect (or even demand) a series of appropriate intervention actions for the purpose of averting the inappropriate labeling of low achieving students as handicapped?

What are the most effective interventions? What is our expectation of the preventative nature of an effective intervention? Perhaps it is not possible to comprehensively answer these questions until we have examined how interventions are viewed by teachers, the "foot-soldiers" in the trenches of regular education. Before we suggest the most effective preventative interventions, we need to examine the potential use of interventions prior to, or instead of referring students to special education, to identify viable intervention options, and to reconceptualize intervention practices to include the concept of multiple-component interventions as preventative measures. Although we need to talk to teachers before we begin, the effective schools literature offers some interesting

possibilities of viable intervention options.

What are viable intervention options? Viable options must be practical enough to be applied within regular classrooms and foster success among low achieving, "at risk" students. Viable intervention options consist of strategic actions, which are goal-directed and intended to have a planned effect. Viable interventions employ strategies associated with student success. Current literature focusing on components of effective schools suggests that variables of student, school, and community characteristics are associated with helping students achieve success in school. Most of these components can be incorporated into instruction for all students. Within the context of successful schools, intervention options tend to fall into four general categories of strategic interactions. Many of these strategies are the direct result of the pioneering efforts of special education researchers and practitioners. This is not to say that special education invented and claims rights to viable intervention options. Regular education has developed and used a number of viable interventions, also, particularly in compensatory educational programs. Recently, a Montgomery County Public Schools (MD) committee assigned to describe successful programs and strategies suggested categorizing these strategies in the following ways:

Teacher/Student Strategies. Direct instruction and cognitive training are examples of strategies involving interactions between the teacher and students. Many teacher/student strategies use specific and strategic actions to obviate clearly defined classroom academic or behavior problems. For example, "Reciprocal Teaching" strategically uses teacher/student interactions to circumvent specific reading comprehension problems (Palincsar & Brown, 1984). "Cognitive Behavior Modification" strategies are used to check behavior problems (Bouchard-Ryan & al., 1986). "Learning Styles" strategies attend to student cognitive, affective, and cultural characteristics (Carbo, 1983; Dunn & Dunn, 1978; Griggs, 1985). Training students in "Metacognitive Strategies" teaches them how to learn, and how to monitor and maintain control over their own learning and comprehension processes (Baker & Brown, 1980; Brown, 1975; Deshler & al., 1984). These are viable intervention options for use with "at risk" students in regular educational programs.

Student/Peer Strategies. This category includes interventions involving interactions between students who strategically use a variety of strategies, to alter specific academic and behavior problems. Peer support groups, peer tutoring, and cooperative learning strategies, all of which are designed to restrict the effects of low achievement, limited social skills, and other typical "at risk" indicators are among intervention options used in both regular and special education. (Slavin, 1980; Slavin & Oickle, 1981; Slavin, & al., 1983).

Teacher/Peer Strategies. These strategies include strategic interactions between teachers and their colleagues to improve their coping and instructional skills. Mentoring, team teaching, collegial coaching, and various consulting teacher activities are interventions that provide teachers with problem-solving skills and as such, these skills probably go a long way toward improving instruction for "at risk" students.

School Organized Strategies. This category includes school-wide efforts focusing a broad range of strategies upon problems endemic to particular settings and groups. Bilingual parent support groups, after-school or Saturday tutoring, and parent volunteer programs are examples of strategies involving school, home, and community in integrated efforts to help low achieving students. These intervention options may include programs with entrance and exit criteria with both long and short term goals. Some are informally developed within individual schools and funded "on a shoestring"; others are formal arrangements funded by local, state and federal agencies.

What interventions are currently in use? Perhaps, it is strategic actions such as those listed in the previous section of this paper, that are most effective with students who are experiencing learning and behavioral problems, but who are not handicapped. Much of the documented support for the majority of the strategies in the preceding categories comes from research and practice of special educators working with a variety of mildly handicapped students. Methods previously used with mildly handicapped students, such as perceptual-motor and visual-motor training are no longer used as much because these techniques taken alone have failed to yield effective results. Thus, many of the so-called deficit model methods are no longer on the cutting edge of effective practice. Currently, instructional approaches such as cognitive and metacognitive strategies, peer tutoring, direct instruction, cooperative learning, all of which are effective with mildly handicapped students, may prove to be very effective as preventative interventions for "at risk" low achieving students.

The skills used most effectively for mildly handicapped students are most likely to be skills that are conceptually similar to those that are considered to be good teaching. Instructional skills currently used by the most successful educators, if adapted to regular classrooms, may serve as preventative interventions. Current practices found in effective schools and effective special education programs represent advances in developing potential intervention approaches. It is possible that some special educators have yet to incorporate the best of these skills into their instructional programs, while some regular educators have initiated incorporation of these skills in their classrooms. Shepard (1987) observes that some special education teachers seem to have this knowledge; however, it has limited accessibility for regular classroom teachers. In addition, Shepard (1987) observes "that current special education specialists have a greater repertoire of skills for coping with learning difficulties, and these are the very skills regular teachers should acquire to preclude the need for a separate category of inappropriately labeled low achievers...Teachers are ill at ease with hard to teach children and refer them to special education. As a result, teachers become increasingly unable to respond to a range of individual differences in regular classrooms."

In a sense, regular and special education teachers have colluded to relieve regular teachers of responsibilities for teaching children functioning at the bottom of their class. Perhaps, the incentive for incorporating systematic preparation in such techniques as direct instruction and cognitive training strategies, for example, is reduced in general teacher training programs since such approaches may be perceived as BELONGING to special education (Pugach, 1987). What else stands in the way of

identifying the most effective interventions for use by regular classroom teachers? Perhaps it is in our failure to conceptualize initial interventions as preventative activities. The problem is compounded by increasingly higher academic standards for all students, thus exaggerating the trend to refer low achieving and hard-to-teach students to special education (Sapon-Shevin, 1987; Pugach & Sapon-Shevin, 1987).

What do regular education teachers do within the classroom to deal with academic and behavioral problems? Perhaps, teachers are likely to structure limited environmental interventions, whenever they initially observe problems, using strategies such as: changing students' seats, materials, work groups, or adjusting workload and/or teacher expectations of productivity. If limited classroom efforts do not bring desired results, heavy-duty actions such as, retention, pull-out programs, parent contacts, and referrals to in-house evaluation teams or resource teachers may be used.

Harrington and Gibson (1986) found that teachers initially tried adapting materials, using another teaching approach, using behavior management techniques, selecting different instructional materials, changing student seating, or enlisting help from "pull-out" remedial reading, math and/or counseling programs. Quite a lot of qualitative information is missing from the preceding list of strategies. For instance, what kinds of "other teaching approaches" were used? How were materials "adapted"? What type of behavioral management methods were used? Because we know so little about what is used, we need to collect and study the qualitative aspects of interventions currently in use. When teachers are asked if they try any type of intervention before referring students to special education, most will undoubtedly say, "Yes!". However, what do we know about the qualitative aspects of "tried interventions"? How many things do teachers try before referrals; what do they try; and why--oh why--do they choose to try them?

What are some qualitative aspects of prereferral interventions? Currently, prereferral interventions are viewed as all inclusive actions and we assume that they are preventative. However, if we look at the qualitative aspects of interventions we may find discrepancies among the student problem, action taken, and the purpose of the intervention. In other words, if we assume that all interventions are strategic measures which will foster positive changes in students' academic or behavioral progress, we may be mistaken. If we expect all prereferral interventions to be preventative or to prohibit an inappropriate special education label, we may find this assumption does not hold up under closer scrutiny. Therefore, I am suggesting at least three possible ways of looking at prereferral interventions, as PROACTIVE, REACTIVE, AND PROTENSIVE actions.

PROACTIVE INTERVENTIONS. In the best of all possible worlds, some interventions seem to be "proactive", in that they involve some type of strategic modification at the classroom level to help "at risk" students before they slide into the special education river. Strategic interventions consisting of integrated, goal-directed actions designed to have a planned effect would forestall a referral to a special education evaluation team. In the case of a typical "at risk" student, experiencing a reading comprehension problem, a positive proactive intervention might involve classroom activities such as "reciprocal teaching" (Palincsar & Brown, 1984). However, selection of the most effective intervention would depend

upon clarification within the teacher's mind of the following:

- the problem (objectively and comprehensively described)
- the action to be taken (careful selection of a viable intervention option)
- the purpose of the intervention (anticipated effects)

Proactive interventions, at their best, integrate problem, action, and purpose to help low achieving, "at risk" students succeed in the regular classroom. Proactive interventions are, in effect, a carefully considered, goal-directed integrated intervention plan. Defining the problem in an objective and comprehensive fashion is essential. Sometimes it is easy to assume the problem is with the child; however, it is entirely possible that the process of actually defining the problem will help to clarify the role of the classroom setting, curriculum, instructional methods, and materials as factors having some effect or perhaps precipitating the problem.

Identifying the best action (strategy) occurs once the problem is described. Notice that the starting point does not begin by describing the child as "defective"; rather, the problem is described as an instructional problem, which may stem from several factors. Selection of viable intervention options occurs and the purpose of the intervention's anticipated effects are considered in light of the problem. Some special educators probably use proactive interventions often, but these occur after the child is labeled. Ideally, if proactive interventions become a part of regular education instructional fare, we anticipate that these interventions would be preventative. Their use permits low achieving students an opportunity to obtain appropriate resources at the classroom level instead of receiving an inappropriate handicapping label.

Unfortunately, we don't live in the best of all possible worlds, so sometimes attempts to provide "proactive" interventions run amuck. Why? What goes wrong? Some difficulties with proactive interventions occur because there is a discrepancy between some aspect of the problem, action, and/or purpose. Absence of an integrated plan and lack of a planned effect can sabotage the best attempts to use interventions proactively. Typical unsuccessful proactive interventions include actions that teachers use within the classroom to help students having problems that may, in fact, doom the student to failure. This is not to say that the teacher intends for the child to fail. In effect, the teacher fails to behave strategically. Problems seem to come from poorly defining the problem, failing to select a viable intervention, or failing to anticipate purpose or desired effects.

For example, what type of intervention does a typical teacher use with a child who is having memory problems? Does he/she remind the child to remember, give the child checklists which the child must remember to give to the parent, or does the teacher call the parents to remind them about important assignments. We anticipate that using any or all of the above would result in an unsuccessful proactive intervention. In the end, the child still has trouble remembering. In other words, sometimes the intervention doesn't work, especially if the student is stuck trying to use something (memory skills) which he/she has as a limited function, "to fix" (i.e., repair) something that he/she needs to get as a function (learning how to remember things). On the other hand, successful proactive interventions in this case might include teaching the child a variety of appropriate memory strategies (based on metacognitive strategies) which

could be used in various situations.

Whenever interventions lack integration of a comprehensively and objectively defined problem, action (selection of a viable intervention), and purpose (anticipated effects of the intervention) they will be unsuccessful. Thus, proactive interventions may fail to be preventative if they are not used strategically.

REACTIVE INTERVENTIONS. In the worst of all possible worlds, some interventions appear to be "reactive". Reactive interventions occur in response to a stimulus, such as stress. Reactive interventions are non-strategic actions, which lack a goal-directed, integrated, planned effect. Perhaps, it is fair to say reactive interventions consist of potentially destructive or obstructive actions. Reactive interventions focus on the problem, which incidently seems to be described as the "student's problem" and an action to redirect the problem elsewhere, usually outside of the classroom. Qualitatively, reactive interventions have a different focus from proactive interventions. The purpose or anticipated effects are missing or designed, either tacitly or explicitly, to bring about negative effects. True reactive interventions do not seem to provide integration of problem, action, and purpose. Reactive interventions do not compel a positive effect (i.e., student success) or prevent an event (i.e., inappropriate student referral to special education). The relationship between the action and the purpose is vague, if expressed at all.

Several very common teacher interventions seem to be reactive instead of preventative. Actions taken to retain students (with the same teacher and same instructional methods) or to place them in pull-out programs such as a remedial reading class during regular classroom reading (so they continue to fall behind their peers) seem to be reactive interventions. Referring a child to an in-house referral and evaluation team instead of trying proactive interventions at the classroom level seems reactive. Contacting parents (frequently and unproductively) can be a very reactive intervention.

How can contacting parents (frequently and unproductively) be called a reactive intervention? When questioned, many, if not most, teachers might say that they contact (i.e., phoned) the parent about students' academic and/or behavioral problems. Contacting a parent is not always reactive, in fact, it can be proactive under some circumstances. However, to assess whether the intervention is proactive or reactive, it is important to know more about the quality and quantity of the contacts. It is also important to know more about the circumstances leading to the parent contact. Is the contact initiated in response to a stressful event? Is it a reaction to the child's behavior? What is the focus? What is the purpose of the contact? Is it to enlist the assistance of the parent as a participant in applying an intervention? Is it to get more information about the student? Is it to let the parent know that things are not going well, or to prepare the parent for an eventual meeting with the school placement team, or is it motivated by a teacher who feels obligated by procedure to comply with school policies?

Brantlinger (1987) conducted some interesting surveys of low-income parents to ascertain their feelings about regular and special education services. Although she did not report the exact numbers, she indicated that some

parents agreed to special education placements for their children to avoid the negative aspects of the regular education setting. Regular education was taken to task for its low appraisals of their children, and what parents described as unhelpful and complaining teachers. "Most agreed to placements because they were tired of poor grades, failure, teacher complaints (perhaps, translated into repeated phone calls) and the general hassle of their children's regular education experience." These parents seem to describe, at the very least, no intervention (failure) and at the very worst, reactive interventions (hassles and phone calls).

And what are the potential effects of retention when it is cited as a prereferral intervention? Is retention preventative? The Harvard Education Letter (1986) notes that strict promotion policies make teachers' jobs easier by limiting the range of achievement in each grade. However, having a student repeat a grade costs about \$3500 and despite volumes of research, we have no persuasive evidence that retention helps students learn (page 3). More than sixty studies have examined the effects of retention on children's achievement---but methodological limitations restrict the findings and teach us few lessons. What we do know is that not one of the fourteen most recent reviews of retention research has endorsed retention as an effective way to intervene on behalf of "at risk" students (page 1). Although, if you asked teachers about it, some will probably cite it as a viable intervention, despite the fact that typical retentions often involve repetition of the previous year's instructional failures, perhaps even with the same teacher.

Pull-out programs in reading and math seem to be reactive interventions, in that the problem, action, and purpose may not be integrated. Careful research is needed to assess the circumstances leading to the best use of these programs as preventative interventions. Once again, the potential effect seems to be reactive. If the purpose is to send the child with reading problems out of the classroom for reading during reading class so he/she won't be disruptive, the intervention seems reactive. A pull-out reading class may be reactive if the purpose is to send the child out to learn reading skills (such as phonics) which are not particularly relevant to the child's regular class (fifth grade, English/Reading) curriculum. The intervention has negative potential since the student can anticipate getting further and further behind his/her peers. We suspect that many basic reading programs use remedial methods that have decided limitations, the effect of which may be to cause the formation of a cumulative reading deficit if the student's exposure to comprehension and curriculum activities are curtailed.

Procedural and compliance issues generate sufficient stress to cause reactive interventions. Due process effects may, according to Budoff (1979) cause staff to become obsessed with meeting the requirements for special education until the staff cannot muster the added energy to imaginatively address the actual instructional needs of mildly handicapped students or low achievers. Adequate documentation suggests that regular classroom teachers who refer students for comprehensive evaluation expect students to be tested and placed in special education programs (Yaseldyke, Christenson, Pianta, and Algozzine, 1983). Some evidence suggests that students are referred to school based evaluation teams when they exhibit "at risk" academic and behavior indicators which flag them as low achievers. Are teachers feeling pressure to refer children with problems to special education specialists rather than deal with the problems themselves? Are students referred to evaluation teams and labeled (perhaps inappropriately) because reactive

interventions are used? We anticipate that studies of reactive intervention effects will identify cumulative negative effects, especially with "at risk" low achievers.

PROTENSIVE INTERVENTIONS. In the better of all possible worlds, "protensive" interventions are viable intervention options. As we reexamine the concepts embedded in preventative interventions, perhaps some are best described as protensive. Protensive interventions are not only strategic, but also precautionary actions having continuance in time. In other words, protensive actions are designed to systematically and collectively extend viable preventative strategies to save "at risk" low achievers. Protensive interventions involve integration of problem, action, and purpose in much the same fashion as "proactive" interventions. However, "protensive" actions involve many proactive interventions which take place over time to address multiple problems for the explicit purpose of helping the "at risk" low achieving student achieve success and avoid inappropriate referral and placement in special education.

For example, a student with poor self-concept, home problems, low achievement in reading and math, and memory problems, all of which guarantee a special education label in some settings, would be a candidate for protensive interventions. Systematic intervention efforts would be interposed at the classroom (teacher, student, peers), and perhaps even at the school level. Effective protensive interventions would be applied prior to, and/or instead of referring this student directly into the referral-to-placement lockstep. Combinations of strategies, such as: peer tutoring to support the math problem, reciprocal teaching within the regular classroom to obviate the reading comprehension problem would be used. In-school counseling programs to teach the child coping strategies for the home problems and to improve self-concept would be included. Metacognitive strategies would be viable options for improving the student's memory. Instructional support for many of these interventions could come from consultative teacher activities using the resource teacher in the regular education classroom helping both teacher and students. Protensive interventions would extend over a period of time with adequate monitoring and adjustments as the success of various interventions were evaluated. Interventions would consist of integrated actions designed to address specific problems for multiple purposes, all of it designed to help the student achieve success and avoid an inappropriate special education label. Such an approach of an integrated continuum of interventions over time would probably require extensive research and a complete reevaluation of the role of resource teachers and specialists within school systems. Thus, further examination of the effectiveness of various protensive interventions are needed if we are to design efficacious preventative interventions for "at risk" low achievers.

What can we say about qualitative aspects of preventative interventions?

The action to select a viable intervention option can be limited by school policies or teachers' knowledge, training, and experience. Also, it seems possible that interventions are influenced by the philosophy of individual teachers and schools, especially if either teachers or schools possess a strong notion that "what works for some students, should work for all." The effectiveness of preventative interventions is further compounded in school settings where special education is perceived by the staff as the "poker player with the best cards in the deck". It is perhaps a sustained

conclusion that any child referred will be labeled in order to gain access to desired resources. When we talk to teachers and examine exactly what occurs at the classroom level, we may discover that many "so-called" interventions are actually inadvertent, non-strategic, or ill-advised actions likely to move students with academic and/or behavioral problems out of the regular classroom, and into special education.

What can we conclude from these comments? Recent estimates show as many as half the handicapped students in some states are "called" learning disabled. After reviewing the state of the art, some observers conclude that screening and diagnosis activities are so flawed and limited, it is time to redirect resources toward corrective and preventative educational interventions. Simulation studies indicate a widespread tendency to classify students in spite of average performance scores, and classroom observations describe few changes in regular education instruction programs for partially mainstreamed mildly handicapped as a result of labeling. Algozzine and Ysseldyke, (1986) describe the absurdity in ignoring the mass of data which indicts the current diagnostic procedures. With the integrity of diagnostic instruments in question, it is unlikely that "new improved tests" will provide any more help for low achievers. In fact, it is likely that schools will continue to find themselves using precious special education resources for diagnostic testing and, as budget belts and diagnostic criteria are tightened, limiting or excluding supports for "at risk" students. Schools may be facing the dilemma of excluding low achievers from special education services without a back-up plan of any kind to provide instructional supports. Since resources are already being used at an alarming rate for special education screening and diagnosis, perhaps resources should be diverted to make all education more special. Placing more supports at the prereferral level to prevent inappropriate referrals to special education may prove to be cost-effective. Although this position seems to be a radical view to some observers, in the end, special education may gain more than it loses.

Our research base in special education offers a rich foundation for further exploration of preventative intervention methods. In regular education, the current reality is that besides such strategies as early preschool interventions, (often consisting of screenings), various reading instructional approaches, behavioral management techniques, metacognitive strategies, and teaching at the student's level of readiness, few purposeful preventative prereferral interventions are systematically applied (Smith, 1986). Many conclusions about effective interventions appear to be assumptions based upon systematically replicated research programs which have focused upon mildly handicapped in special education.

Much needs to be learned about "at risk" students because no one comprehensively integrates the present state of knowledge regarding causes, characteristics, teaching methodology, and most effective preventative interventions. Practitioners can not afford to wait for research before initiating changes in prereferral practices at the school level. Much of what is described in this paper as reactive interventions are non-thinking, non-goal-directed, knee-jerk responses to a failure to coordinate regular and special education instruction. Special and regular education need to join forces to examine preventative intervention issues. Special and regular education must examine instructional methods to reduce the necessity for very intensive, special education interventions. Research is needed to

further develop and validate preventative strategies for "at risk", low achieving students who may be labeled if school resources are used inappropriately. In addition, research is needed to examine various resource teacher roles for mildly handicapped and "at risk" low achieving children who are prime candidates to be referred and placed in special education programs.

We need to support comprehensive efforts to work with regular education. Prereferral intervention efforts can be improved by implementing preventative intervention strategies and by evaluating their effects **BEFORE** a student is referred. Perhaps this is the only sure way to break the chain of referral-to-testing-to-labeling actions currently in vogue. We must examine the qualitative aspects of interventions. The contrasts between strategic and non-strategic interventions, which are described in this paper as proactive, reactive, and protensive actions suggest that we can not assume that prereferral interventions are preventative. If, in fact, present interventions do tend to become PROACTIVE, REACTIVE, or perhaps, even PROTENSIVE, in some school settings, we need to look at this. Clearly the "at risk" student is a concern to regular education and special education teachers who observe the present fate of students whose failure to "fit into regular programs" labels them as outsiders and mislabels them as handicapped within the very system that claims to provide equitable opportunity for all, and in a least restrictive environment, too. The irony of this phenomena is quite clear.

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